

The man made a good recovery from the operation, and will continue to attend the hospital as an out-patient. The right eye has decidedly improved. It is less irritable, and the pink appearance has disappeared. No amendment, however, can take place in the vision until some operation has been performed, as the pupil is bound down to the lens capsule, and the pupillary area is blocked up with lymph.

Clinical Remarks.—This case is a sad, but a very instructive one. It illustrates the danger of allowing a foreign body to remain in the eye, even though the eye for all useful purposes has been destroyed by it. Sooner or later it is certain to be a source of pain and trouble to the patient, and to induce an inflammation in the injured eye, which is peculiarly liable to excite a sympathetic ophthalmia in the sound one. In this patient there are some points worthy of notice.

1st. The injury was caused by the explosion of a cheap percussion cap. Unfortunately these cheap caps are made of an inexpensive and brittle alloy, and scales of them often become detached during explosion, and fly off with such violence as to lodge themselves in any portion of the body with which they come in contact. In nearly all the eyes which are destroyed by percussion caps, and they are many, it will be found on inquiry, that the caps used were the toy, or the cheap ones, such as children buy for their play guns, or such as are employed in firing at targets in the streets for nuts.

2d. The length of time which a foreign body has remained imbedded in an eye, is no guarantee that the danger of its presence has passed. In this patient over seven years elapsed before it began to give trouble, but when the stump of the lost eye became inflamed, the sound eye was speedily involved in that terrible disease, now so well known as sympathetic ophthalmia.

3d. The sound eye in this patient was sympathetically affected without its suffering in the first attack any pain as a warning of its presence, and this is one of the peculiarities of the disease. It will often creep on unheeded by the patient, the impairment of the sight being so gradual as at first not to draw sufficient attention to it; and it frequently happens that the disease is fully established before it comes under the surgeon's care.

Since the source of irritation, the stump of the lost eye, with the foreign body within it, has been removed, the other eye has decidedly improved.

Time must now be allowed for all irritation to completely subside, and after an interval of some months if the eye continues so long in a quiescent state, an operation will be performed to establish a new pupil, and if the lens on the removal of a portion of the iris, should be found cataractous, it will be removed. There is yet a fair prospect that the man may recover a useful eye.

34. *On Excision of the Eyeball in the Acute Stage of Traumatic Ophthalmitis.*—By JONATHAN HUTCHINSON, Esq. As an opinion is, I believe, held by some high authorities that the excision of globes when acutely inflamed is dangerous, I think it desirable to record the fact that during the last year I have performed numerous such operations without the slightest ill result. Whenever I am satisfied that an injured globe is utterly lost, I always advise its excision without loss of time. By adopting this course the patient's suffering, often extreme, is at once put an end to, and I think, also, the risk of sympathetic inflammation of the other eye is avoided. I have excised globes in all stages of inflammation, and have never seen the slightest ill consequence, whilst the patients have invariably been most grateful for the complete relief afforded. The hemorrhage is usually rather more than when the cellular tissue is not infiltrated, and the operation is much less easy of performance (especially when the globe is in a state of proptosis from inflammation), but these are objections of very minor consequence. In a recent case of peracute inflammation after a blow, in a poor girl of 18, the globe was pushed out of the orbit by swelling, the lids partially everted, and the conjunctiva chemosed. In this case, owing to the matting together of the tissues, and the soft, flabby state of the sclerotic, I had more difficulty in the excision than I could have believed possible. Although, after the removal of the globe, the lids were still left tense, dusky, and prominent from swelling, yet the most complete relief was given, and the patient, who had

been out by ten days and nights' incessant suffering, was looking quite happy on the following day.

A month ago I excised an eyeball on account of traumatic ophthalmitis within forty-eight hours of the accident—by much the shortest period within which I have ever felt justified in advising the operation.¹ A lad of 14 was going through the street one Saturday evening, and stopping to watch a man shooting on a nut-stall, the cap flew, and a fragment entered his eye. Severe pain commenced at once. He came to me on the Monday morning with a small hypopyon, the posterior lamina of the cornea dotted over with small accumulations of puro-lymph, acute iritis, and opaque vitreous. He had no perception of light. Mr. Dixon and Mr. Streatfeild both saw him with me, and both agreed in the opinion that, although the cornea was still almost clear, there could be no doubt that the organ was lost. The lad willingly consented to its removal, so great had been his suffering. After excision I found a portion of gun-cap behind the ciliary processes, the whole region of which was covered by puro-lymph in a coherent membrane. The vitreous was still, for the most part, translucent; but in various parts of its substance films of yellow lymph were visible. There was also lymph on the surface of the retina at almost all parts. At so early a stage of the inflammatory process, in such a structure, microscopic examination would have been most interesting, but I was compelled, by the pressure of engagements, to let the opportunity slip.—*Royal London Ophthalmic Hospital Reports*, Dec. 1866, vol. v. pt. 4.

35. *New Method of Extracting in Cases of Cataract.*—Dr. C. B. TAYLOR, Surgeon to the Nottingham Eye Infirmary, writes to the editor of the *Ophthalmic Review* (see No. for April, 1867) that he "was led to work out this method from observing the disastrous results of two cases operated upon with Schuett's spoons, and from having in my own practice a case operated upon by Mooren's method, in which the flap was accidentally turned down some hours after the successful completion of the operation. It struck me, then (Oct. 1865), that, to insure success in such cases, it would be necessary to make an incision flap-like, and large enough to permit the exit of the lens without the use of any traction instrument, and yet not so large as to be liable to be forced forwards by protruding vitreous, or reflected by any sudden accidental or involuntary motion of the patient. After numerous experiments upon pigs' eyes, and some operations on the dead subject, I arrived at a solution of the problem, and have since operated by the method about to be described, in all cases of senile cataract coming under my care."

He calls this method "extraction by linear flap." In his first cases he "used a ground-down cataract-knife, reduced to about the size of the ordinary secondary cataract-knife, sold in most cases of ophthalmic instruments; but since reading an account of von Gräfe's method, I have adopted his knife. As the risk, even if vomiting occurs, is very slight with this form of incision, I prefer to have the patient narcotized. Keeping the lids apart with the stop speculum, I fix the eye with a pair of forceps, and enter the knife about the junction of the middle with the upper third of the cornea, say $2\frac{1}{2}$ lines lower down than the point of incision in von Gräfe's method, and rather more forward in the corneo-sclerotic junction, bringing out the point at a counter-puncture similarly placed; I hold the knife parallel to the iris, and cut upwards about two lines and a half, then turn it forwards, and complete the section by a gentle sawing movement, thus forming a very small elongated flap, situated well back in dense tissue, with sloping sides and transverse centre, which last occupies the summit of the true cornea.

"I argued, and frequently demonstrated, that such a wound would be large enough for the exit of the lens if its posterior lip were gently pressed back and the eyeball manipulated; while, being made in the dense tissue of the corneo-sclerotic junction, it would not gape or be pushed open by protruding vitreous.

¹ This statement, of course, applies only to removals on account of the inflammation, and not for the direct effects of the injury. Where the eyeball was hopelessly destroyed by laceration, I have sometimes removed its remains immediately.